GAJJU KHAN MEDICAL COLLEGE SWABI

LOG BOOK

 3rd Year MBBS



DEPARTMENT OF MEDICAL EDUCATION

# About the student

Paste your Resent Passport size Picture

Name of the student: Father`s name:

Class:

Roll No:

Batch:

Session:

Year of induction in GKMC:

 Address:

Contact no. of student:

Contact no. of father / guardian: Email:

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# Purpose of Logbook

This Logbook is intended to develop, record, assess and certify student`s skills during pre clinical and clinical rotations. These skills are based on the learning objectives defined in the curriculum document. Recording and certification of clinical and educational activities provides objective evidence during assessment of student and evaluation of the overall performance of institution and curriculum. Adding reflection by students during activity log enhances the academic performance of students. A section of reflection has been added to this log book with the intent to convert this document into a reflective portfolio in future. Record of these activities will ultimately improve patient safety, as the students will be aware of their limits, duties and responsibilities.

Director Medical Education Gajju Khan Medical College

# Objectives of clinical rotations

Clinical rotation is one of the integral parts of undergraduate medical students that usually start at 3rd year. However, in contemporary programs, rotations in clinical activities start right at the start of training as part of integration attempt. This document will be extended in future amongst students of early years. Clinical skills learning require the exposure of students into clinical environment. The objectives of these rotations include:

1. Application of concepts in real life situations which is being presented in lectures and books.
2. Acquisition of clinical skills relevant to the level and understanding of students
3. Understanding the concepts of patient safety, hospital organization and roles of doctors in clinical situations
4. Developing communication skills, patient management skills, team work, time management skills, and interdepartmental collaboration at workplace
5. Developing and enhancing professionalism in medical students

It is important to mention that this logbook is not only intended for the above- mentioned purposes, but include other activities and accomplishments of students like research, presentations and record of participation in co-curricular activities.

# How to use this Logbook

The log book is divided into sections according to the specialties and units whom the students visit. Rotation in each unit is represented into 3 parts; 1st part represents clinical skills required of students, 2nd part relates to other activities like knowledge imparted during rotation, record of history taking, field visits, assessment marks and student`s reflection. The 3rd part includes attributes of communication skills and professionalism. All the students are required to dully attest each activity in the log book. The log book also includes record of activities not related to clinical rotations. Those activities include, presentation skills, record of research publications, co- curricular activities and many others. At the end, there is record of student’s attendance, and end of rotation assessment marks that should be completed by the student affairs / examination section. This log book will have an important weightage in final assessments of students and students who fail to present this log book in final assessment will not be considered for promotion to next class. Students are advised to make a copy of all these activities so that it can be retrieved in times of loss of log book at the end of the year. It is important to mention that level of competence has been shown in individual rotations as follows:

Level A: Observer status Level B: Assistant status

Level C: Performed part of the procedure under supervision Level D: Performed whole procedure under supervision Level E: Independent performance

Third year students will achieve only level A and B in most of the situations except a few where patient safety is not endangered.

Methods of writing Reflection in the Logbook

Reflective thinking and writing demands that you recognize that you bring valuable knowledge to every experience. It helps you therefore to recognize and clarify the important connections between what you already know and what you are learning. It is

a way of helping you to become an active, aware and critical thinker and learner.

It is mandatory for students to write about his / her experience and reflective thinking of clinical rotation in each unit in the space given in logbook. The reflective document includes the description about the following points:

1. Description of an event
2. Thinking and feeling of student
3. Good and bad about the experience
4. How to avoid bad experiences and pursue good experiences in future

# Contents of clinical rotations

In 3rd year, the MBBS students are rotated in following departments in groups of about 10-15 students:

1. Medicine & allied
2. Surgery & allied
3. Gynecology
4. Pediatrics
5. Ophthalmology
6. Otorhinolarygology
7. Forensic Medicine & Emergency Department

In the next sections, a list of competencies, level of achievement, professionalism attributes and supervisor`s observations / approval with dates are mentioned.

**Evening ward teaching**

All subspecialties do not have separate wards for patients so far except Neuro, Ortho and ENT (they are in one unit upstairs). Therefore their patients are managed in Medicine & Allied and in Surgery & allied units. Students on rotation to these units will come to Medicine, Surgery units in evening from 6 pm to 8 pm.

Evening ward learning is self directed, group discussion based and active learning. Students are supposed to take histories, examine patients, and discuss among themselves their cases on bedside and in tutorial room of the ward. They can discuss learning issues with the doctors in the ward at that time or can present and discuss with their teachers next day morning.

# General Medicine

# Date of Entry:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | **History taking**  |  |  |  |  |  |  |
| 2 |  | 1. Introduction
 |  |  |  |  |  |  |
| 1. Identification of the patient
 |  |  |  |  |  |
| 1. Demographic details
 |  |  |  |  |  |
| 1. Detailed history
 |  |  |  |  |  |
| **Examination**  |  |  |  |  |  |
| 1. General physical examination
 |  |  |  |  |  |
| 3 |  | * Follow standards of Infection prevention and control
 |  |  |  |  |  |  |
| * Pulse
 |  |  |  |  |  |
| * Blood Pressure
 |  |  |  |  |  |
| * Temperature
 |  |  |  |  |  |
| * Respiratory Rate
* Pulse oximetery
 |  |  |  |  |  |
| * Skin pigmentations
* Wounds
* Bites
* Rashes
* IV Lines
* Catheters
* Drains
 |  |  |  |  |  |
| 4 |  | * Height
* Weight
* BMI
 |  |  |  |  |  |  |
| 5 |  | 1. Systemic examination
 |  |  |  |  |  |  |
| 6 |  | * GIT
 |  |  |  |  |  |  |
| 7 |  | * CVS
 |  |  |  |  |  |  |
| * Respiratory
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| * CNS
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| * MSS
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| * GUS
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| --- | --- | --- | --- | --- |
| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 8 |  | Making Differential Diagnosis |  |  |  |  |  |  |
| 9 |  | Investigations |  |  |  |  |  |  |
| * Blood
* Urine
* Tissue
* CSF/ fluids
* Radiology
* Others
 |  |  |  |  |  |
| Correct method of sample collection |  |  |  |  |  |
| * Blood
* Urine
* Ascitic fluid
* Pleural fluid
* CSF
* Synovial fluid
* Others
 |  |  |  |  |  |
| * Labelling
 |  |  |  |  |  |
| * Packing
 |  |  |  |  |  |
| 10 |  | Interpretation of different investigations |  |  |  |  |  |  |
| Writing Daily progress report |  |  |  |  |  |
| Writing a consult call |  |  |  |  |  |
| Counselling/ Breaking bad news |  |  |  |  |  |
| Writing discharge summary |  |  |  |  |  |
|  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |  |

**Presentation skills and procedures**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Personal skills | Presented case histories | 1)2)3) |  |
|  | You have to write 6 histories in ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol | Mention final diagnosis 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | Presented short cases in OPDWARD  | OPD1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WARD1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  | **A** | **B** | **C** | **D** | **E** |  |
| Procedures / Interpretations | Recording * Body Mass Index
* Ideal Body Weight
* Body Surface Area
* Blood Pressure

Performing* Aseptic venipuncture
* IV Cannula Insertion
* Pleural fluid aspiration
* Ascitic fluid aspiration
* Electrocardiogram
* Nasogastric tube insertion
* Foleys catheter insertion
* others

 Interpretation* ECG interpretation
* Chest Xray Interpretation
* CT SCAN interpretation
* MRI interpretation
 |  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Introduction to Common symptoms anddiseases in General Medicine | Presented by: |  |
| Details of history and examination\* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment andfollow-up protocol | \*Mention 3 symptoms and system involved1)2)3) |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details)  |  |
| Reflection by student  |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses, paramedicalstaff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

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| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Emergency Department**

# Date of Entry:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
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**Details of other activities**

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| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Introduction to Common symptoms anddiseases in General Medicine | Presented by: |  |
| Details of history and examination\* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment andfollow-up protocol | \*Mention 3 symptoms and system involved1)2)3) |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details)  |  |
| Reflection by student  |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses, paramedicalstaff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

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| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

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Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Neurology unit**

# Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | **History taking**  |  |  |  |  |  |  |
| 2 |  | 1. Introduction
 |  |  |  |  |  |  |
| 1. Identification of the patient
 |  |  |  |  |  |
| 1. Demographic details
 |  |  |  |  |  |
| 1. Detailed history
 |  |  |  |  |  |
| **Examination**  |  |  |  |  |  |
| 1. General physical examination
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| Others (specify) |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Introduction to Common symptoms anddiseases in General Medicine | Presented by: |  |
| Details of history and examination\* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment andfollow-up protocol | \*Mention 3 symptoms and system involved1)2)3) |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses, paramedicalstaff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

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| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Dermatology unit**

#  Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | History taking from a patient inmedical unit |  |  |  |  |  |  |
| 2 |  | General physical examination |  |  |  |  |  |  |
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|  |  |  |  |  |  |
| * Others (specify)
 |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Introduction to Common symptoms anddiseases in General Medicine | Presented by: |  |
| Details of history and examination\* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment andfollow-up protocol | \*Mention 3 symptoms and system involved1)2)3) |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses, paramedicalstaff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |
| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments if any \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pulmonology**

# Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision****D: Performed whole procedure under supervision****E: Independent****performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | General physical examination |  |  |  |  |  |  |
| * BP
 |  |  |  |  |  |
| * Temperature
 |  |  |  |  |  |
| * Respiratory rate
 |  |  |  |  |  |
| * Examination of

respiratory system |  |  |  |  |  |
| 2 |  | * Bronchoscopy
 |  |  |  |  |  |  |
| * Ventilator
 |  |  |  |  |  |
| * Endotracheal intubation
 |  |  |  |  |  |
| * PFTs
 |  |  |  |  |  |
| * DLCO
 |  |  |  |  |  |
| * Sleep studies
 |  |  |  |  |  |
| * others
 |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Introduction to oxygen therapy (modes, indications, limitations) | Presented by: |  |
| Introduction to artificial ventilation (modes, indications, limitations,weaning) | Presented by: |  |
| CBD | By: |  |
| Respiratory failure | Presented by: |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

|  |
| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CCU and Cardiology**

# Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision****D: Performed whole procedure under supervision****E: Independent****performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | General physical examination |  |  |  |  |  |  |
| * Pulse
 |  |  |  |  |  |
| * BP
 |  |  |  |  |  |
| * Temperature
 |  |  |  |  |  |
| * Respiratory rate
 |  |  |  |  |  |
| * Others (specify)
 |  |  |  |  |  |
| 2 |  | * ECG
 |  |  |  |  |  |  |
| * Echo
 |  |  |  |  |  |
| * ETT
 |  |  |  |  |  |
| * Temporary pacemaker

insertion |  |  |  |  |  |
| * Use of defibrillator
 |  |  |  |  |  |
| * Other (specify)
 |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s****comments / signature** |
| CBD | Presented by: |  |
| CBD | Presented by: |  |
| OTHERS activities : 1- | By: |  |
| 2- | By: |  |
| 3- | By: |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses,paramedical staff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

|  |
| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Surgery**

# Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | History taking from a patient insurgical unit |  |  |  |  |  |  |
| 2 |  | General physical examination |  |  |  |  |  |  |
| * Pulse
 |  |  |  |  |  |
| * BP
 |  |  |  |  |  |
| * Temperature
 |  |  |  |  |  |
| * Respiratory rate
 |  |  |  |  |  |
| * Others (specify)
 |  |  |  |  |  |
| 3 |  | Systemic examination |  |  |  |  |  |  |
| * GIT
 |  |  |  |  |  |
| * CVS
 |  |  |  |  |  |
| * Respiratory system
 |  |  |  |  |  |
| * Nervous system
 |  |  |  |  |  |
| * Other (specify)
 |  |  |  |  |  |
| 4 |  | * First aid
 |  |  |  |  |  |  |
| 5 |  | * Nasogastric tube insertion
 |  |  |  |  |  |
| 6 |  | * Foley`s catheter insertion
 |  |  |  |  |  |
| 7 |  | * Wound care including D/D
 |  |  |  |  |  |
| * Apply bandage / splint
 |  |  |  |  |  |
| * Others (specify)
 |  |  |  |  |  |

**Surgical unit**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 8 |  | venous blood sampling |  |  |  |  |  |  |
| 9 |  | I/V injection |  |  |  |  |  |  |
| I/M injection |  |  |  |  |  |
| I/V canula insertion and removal |  |  |  |  |  |
| I/V infusion set up |  |  |  |  |  |
| wound dressing |  |  |  |  |  |
| BP recording |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Introduction to Common symptoms anddiseases in General surgical practice | Presented by: |  |
| Details of history and examination\* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment andfollow-up protocol | \*Mention 3 symptoms and system involved1)2)3) |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses, paramedicalstaff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

|  |
| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Orthopedic unit**

# Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | Examination of a trauma patient |  |  |  |  |  |  |
| 2 |  | Application of ATLS principles |  |  |  |  |  |  |
| filling up of investigation form |  |  |  |  |  |
| wound dressing |  |  |  |  |  |
| Bandage techniques |  |  |  |  |  |
| Splintage and immobilization Techniques |  |  |  |  |  |
| Physiotherapy  |  |  |  |  |  |
| 3 |  | Skin traction technique |  |  |  |  |  |  |
| Skeletal traction |  |  |  |  |  |
| venous blood sampling |  |  |  |  |  |
| I/V injection |  |  |  |  |  |
| I/M injection |  |  |  |  |  |
| I/V canula insertion and removal |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Introduction to Common symptoms anddiseases in General surgical practice | Presented by: |  |
| Details of history and examination\* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment andfollow-up protocol | \*Mention 3 symptoms and system involved1)2)3) |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses, paramedicalstaff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

|  |
| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Urology unit**

# Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | History taking  |  |  |  |  |  |  |
| 2 |  | General Physical examination |  |  |  |  |  |  |
| Systemic Examination |  |  |  |  |  |
| Nerous System |  |  |  |  |  |
| Cardiovascular |  |  |  |  |  |
| Abdominal & Genitourinary system |  |  |  |  |  |
| Respiratory  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |
| filling up of investigation form |  |  |  |  |  |
| condom catheter  |  |  |  |  |  |
| Urethral catheterizaion |  |  |  |  |  |
| DRE for prostate  |  |  |  |  |  |
| Continuous bladder wash |  |  |  |  |  |
| 4 |  | I/V cannula insertion and removal |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Introduction to Common symptoms anddiseases in General surgical practice | Presented by: |  |
| Details of history and examination\* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment andfollow-up protocol | \*Mention 3 symptoms and system involved1)2)3) |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses, paramedicalstaff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

|  |
| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Neurosurgical Unit**

# Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | History taking  |  |  |  |  |  |  |
| 2 |  | General Physical examination |  |  |  |  |  |  |
| Systemic Examination |  |  |  |  |  |
| Nerous System |  |  |  |  |  |
| Cardiovascular |  |  |  |  |  |
| Abdominal & Genitourinary system |  |  |  |  |  |
| Respiratory  |  |  |  |  |  |
| 3 |  | GCS charting |  |  |  |  |  |  |
| I/V injection |  |  |  |  |  |
| I/M injection |  |  |  |  |  |
| I/V canula insertion and removal |  |  |  |  |  |
| I/V infusion set up |  |  |  |  |  |
| wound dressing |  |  |  |  |  |
| 4 |  | Prevention of bed sores |  |  |  |  |  |  |
| 5 |  | postural changes |  |  |  |  |  |
| 6 |  | Application of ATLS principles |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Introduction to Common symptoms anddiseases in General surgical practice | Presented by: |  |
| Details of history and examination\* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment andfollow-up protocol | \*Mention 3 symptoms and system involved1)2)3) |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses, paramedicalstaff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

|  |
| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Dentistry & Maxillofacial unit**

# Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | History taking  |  |  |  |  |  |  |
| 2 |  | General Physical examination |  |  |  |  |  |  |
| Oral examination |  |  |  |  |  |
| Nerous System |  |  |  |  |  |
| Cardiovascular |  |  |  |  |  |
| Abdominal & Genitourinary system |  |  |  |  |  |
| Respiratory  |  |  |  |  |  |
| 3 |  | Identification of permanent and deciduous teeth |  |  |  |  |  |  |
| Identification of commonly used dental instruments |  |  |  |  |  |
| Identification of carious lesions, periodontal diseases, impactions and pericoronitis, oral ulcers, dental abscess, mal-alignments of teeth and their first line management. |  |  |  |  |  |
| Identification of various oral and dental radiographs and their interpretation |  |  |  |  |  |
| First line management of the maxillo facial trauma |  |  |  |  |  |
| Tooth extraction (procedure) |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Introduction to Common symptoms anddiseases in General surgical practice | Presented by: |  |
| Details of history and examination\* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment andfollow-up protocol | \*Mention 3 symptoms and system involved1)2)3) |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses, paramedicalstaff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

|  |
| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Gynecology and Obstetrics**

# Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | History taking from a patient inGynae / Obs. unit |  |  |  |  |  |  |
| 2 |  | General physical examination |  |  |  |  |  |  |
| * Venous blood sampling
 |  |  |  |  |  |
| * IV & IM injection
 |  |  |  |  |  |
| * IV canula removal & Insertion
 |  |  |  |  |  |
| * I/V infusion setting
 |  |  |  |  |  |
| * Wound dressing
 |  |  |  |  |  |
| 3 |  | Vaginal / Pelvic examination /obstetric examination |  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| * Other (specify)
 |  |  |  |  |  |
| 4 |  | Deliveries* Normal vaginal
 |  |  |  |  |  |  |
| 5 |  | * Forceps
 |  |  |  |  |  |  |
| 6 |  | * C. Sections
 |  |  |  |  |  |  |

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| **sn** | **Date**  | **Time:morning& evening** | **Topic**  | **Tutor**  | **sig of tutor** |
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**Case presentations**

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Introduction to Common symptoms anddiseases in Gynae / Obs. | Presented by: |  |
| Details of history and examination\* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment andfollow-up protocol | \*Mention 3 symptoms and system involved1)2)3) |  |
| Case Based Discussion (CBD) |  |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses, paramedicalstaff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 7 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

|  |
| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Pediatrics**

# Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pediatrics A unit**

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| --- | --- | --- | --- | --- |
| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | History taking from a patient inPaeds. unit |  |  |  |  |  |  |
| 2 |  | General physical examination |  |  |  |  |  |  |
| * Pulse
 |  |  |  |  |  |
| * BP
 |  |  |  |  |  |
| * Temperature
 |  |  |  |  |  |
| * Respiratory rate
 |  |  |  |  |  |
| * Dehydration status
 |  |  |  |  |  |
| * Mental state
 |  |  |  |  |  |
|  3 |  | * Capillary refill time
 |  |  |  |  |  |  |
|  4 |  | * Palpation of lymph nodes
 |  |  |  |  |  |  |
|  5 |  | * Others
 |  |  |  |  |  |  |
| 6 |  | Growth parameters |  |  |  |  |  |  |
| * Height / length
 |  |  |  |  |  |
| * Weight
 |  |  |  |  |  |
| * Head circumference
 |  |  |  |  |  |
| * Use of centile charts
 |  |  |  |  |  |
| * Role play / counseling

session |  |  |  |  |  |
|  7 |  | * Surgical hand washings
 |  |  |  |  |  |  |
|  8  |  | * Venipuncture / blood

sampling / Injections |  |  |  |  |  |  |
|  9 |  | * Mantoux test
 |  |  |  |  |  |  |
|  10 |  | * Nebulization
 |  |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s****comments / signature** |
| History taking- presentation | Presented by: |  |
| Vaccination schedules (EPI) | Presented by: |  |
| Growth parameters | Presented by: |  |
| Integrated management of neonatal and childhood illnesses (IMNCI) | Presented by: |  |
| Advantages of breast feeding | Presented by: |  |
| Details of history and examination | \*Mention | 3 | symptoms | and | system |  |
| \* You have to write 2 histories in each ward | involved |  |  |  |  |
| along with examination, provisional | 1) |  |  |  |  |
| diagnosis, relevant investigations, results of | 2) |  |  |  |  |
| procedures, final diagnosis, treatment and | 3) |  |  |  |  |
| follow-up protocol |  |  |  |  |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses, paramedicalstaff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

|  |
| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Ophthalmology**

# Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | History taking from a patient in Eyeunit |  |  |  |  |  |  |
| 2 |  | General physical examination |  |  |  |  |  |  |
| * Visual acuity
 |  |  |  |  |  |
| * Examination of adnexa and

anterior segment |  |  |  |  |  |
| * Ocular movements
 |  |  |  |  |  |
| * Pupillary reflexes
 |  |  |  |  |  |
| * Intraocular pressure
 |  |  |  |  |  |
| * Ophthalmoscopy
 |  |  |  |  |  |
| * Confrontation test for field

of vision |  |  |  |  |  |
| * Slit lamp examination
 |  |  |  |  |  |
| 3 |  | Procedures |  |  |  |  |  |  |
| * Irrigation of eye
 |  |  |  |  |  |
| * Instillation of eye drops
 |  |  |  |  |  |
| * Staining of corneal ulcer
 |  |  |  |  |  |
| * Removal of superficial

foreign bodies |  |  |  |  |  |
| * Rational use of topical

anesthesia |  |  |  |  |  |
| * Other (specify)
 |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Introduction to Common symptoms anddiseases in ophthalmology | Presented by: |  |
| Details of history and examination\* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment andfollow-up protocol | \*Mention 3 symptoms and system involved1)2)3) |  |
| Field visit | Details: |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses, paramedicalstaff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

|  |
| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Otorhinolaryngology**

# Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | History taking from a patient in ENTunit |  |  |  |  |  |  |
| 2 |  | Complete regional examination |  |  |  |  |  |  |
| * Ear
 |  |  |  |  |  |
| * Nose
 |  |  |  |  |  |
| * Throat
 |  |  |  |  |  |
| * Neck Lymph nodes and neck examination
 |  |  |  |  |  |
| * Examination of cranial

nerves |  |  |  |  |  |
| * Others (specify)
 |
| 3 |  | Skills |  |  |  |  |  |  |
| * Use of head light
 |  |  |  |  |  |
| * Use of tongue depressor and Examination of oropharynx
 |  |  |  |  |  |
| * Use of nasal speculum and anterior Rhinoscopy
 |  |  |  |  |  |
| * Indirect laryngoscopy
 |  |  |  |  |  |
| * Filling the Xray, Ct scan and laboratory forms
 |  |  |  |  |  |
| * How to fill the biopsy form and labelling of container
 |  |  |  |  |  |
| * Preparation of form and container for Culture sensitivity / fungal studies
 |  |  |  |  |  |
| * Normal ENT X-rays /CT Scan
 |  |  |  |  |  |
| * X-rays/CT scan with positive radiological findings
 |  |  |  |  |  |
| * Tuning fork tests
 |  |  |  |  |  |
| * Demonstrate the use of
* Otoscope and otoscopy
 |  |  |  |  |  |
| * Video Nasopharyngoscopy/ Posterior rhinoscopy
 |  |  |  |  |  |
| * Normal Pure tone audiometry and tympanometry /BERA
 |  |  |  |  |  |
| * Findings of common ear diseases on audiometry and tympanometry
 |  |  |  |  |  |
| * Use of different types of sutures
 |  |  |  |  |  |
| * Use of oropharyngeal airway, Nasogastric tube
 |  |  |  |  |  |
| * Use of Endotracheal tube and tracheostomy tube
 |  |  |  |  |  |
| * Principles of sterilization
 |  |  |  |  |  |
| * How to put on gowns and Gloves
 |  |  |  |  |  |
| * Scrubbing techniques of surgeon and patient/towelling of patient
 |  |  |  |  |  |
| * Use of ENT surgical instruments
 |  |  |  |  |  |
| * On spot diagnosis of common ENT diseases
 |  |  |  |  |  |
| * Other (specify)
 |  |  |  |  |  |
| 4 |  | Anterior nasal packing |  |  |  |  |  |  |
| 5 |  | Ear suction |  |  |  |  |  |  |
| 6 |  | Nasal and ear foreign body removal |  |  |  |  |  |  |
| 7 |  | Tonsillectomy  |  |  |  |  |  |  |
| 8 |  |  Septoplasty/ SMR |  |  |  |  |  |  |
| 9 |  | Functional Endoscopic Sinus Surgery |  |  |  |  |  |  |
| 10 |  | Esophagoscopy  |  |  |  |  |  |  |
| 11 |  | Bronchoscopy  |  |  |  |  |  |  |
| 12 |  | Direct laryngoscopy |  |  |  |  |  |  |
| 13 |  | Different type of Mastoidectomy  |  |  |  |  |  |  |
| 14 |  | Myringoplasty  |  |  |  |  |  |  |
| 15 |  | Head & neck surgery |  |  |  |  |  |  |
| Others (specify) |  |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Introduction to Common symptoms anddiseases in ENT | Presented by: |  |
| Details of history and examination\* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment andfollow-up protocol | \*Mention 3 symptoms and system involved1)2)3) |  |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite with patients, nurses, paramedicalstaff, seniors and colleagues |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

|  |
| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

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Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Forensic Medicine

# Date of Entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **S. No** | **Date** | **Competencies** | **Level****A: Observer status B: Assistant status****C: Performed part of the procedure under supervision D: Performed whole procedure under supervision****E: Independent performance** | **Supervisor`s comments / signature** |
| **A** | **B** | **C** | **D** | **E** |
| 1 |  | * Medicolegal examination

of an injured |  |  |  |  |  |  |
| * Examination for age
 |  |  |  |  |  |
| * Examination of forensic

radiology |  |  |  |  |  |
| * Examination of sexual

assault victim |  |  |  |  |  |
| * Others (specify)
 |  |  |  |  |  |
| 2 |  | Procedure for |  |  |  |  |  |  |
| * Taking consent and

Medical certification |  |  |  |  |  |
| * For preservation and dispatch of biological

material |  |  |  |  |  |
| * Identification of poisons
 |  |  |  |  |  |
| * Other (specify)
 |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor`s comments /****signature** |
| Field visits | By: |  |
|  | 1) |
|  | 2) |
|  | 3) |
| List of autopsies | 1) |  |
|  | 2) |
|  | 3) |
| End of the ward assessment | Marks: out of  |  |
| Any other event that you want to record during your stay in the unit (provide details) |  |
| Reflection by student |  |

**Comments about professionalism and behaviors of students (To be filled by the supervisor)**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| 1 | Was polite |  |  |  |
| 2 | Was ready to take responsibility |  |  |  |
| 3 | Kept calm in difficult situations |  |  |  |
| 4 | Maintained an appropriate appearance /dress |  |  |  |
| 5 | Avoided derogatory remarks in the unit |  |  |  |
| 6 | Presentation skills were up to the mark |  |  |  |
| 7 | Total attendance |  | Out of= |  |
| 8 | Overall assessment of professional conduct | A:High | B:Moderate | C:Low |
|  |  |  |

|  |
| --- |
| **Final evaluation**  |
| Subject | Below expectation | Borderline | Meet expectation | Above expectation |
| History taking skills |  |  |  |  |
| Clinical examination |  |  |  |  |
| Communication skills |  |  |  |  |
| Procedural skills |  |  |  |  |
| Professionalism and behaviour of the student |  |  |  |  |

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Comments if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Other Academic And Co-Curricular Activities**

List of presentations\*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S.****No** | **Title of presentation / lecture** | **Venue** | **Date** | **Signature of supervisor /****organizer** |
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**List of certificates of participation in other academic and co-curricular activities**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| S. No | Name of activity / society / other | Position | From to (date) | Signature of organizer /incharge |
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**For Student Affairs / Examination Section**

### Details of marks of internal assessments

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **S.****No** | **Assessment**  | **Marks obtained** | **Total marks** | **MCQ** | **SAQ** | **OSCE / viva****/ practical** | **%age** | **Pass****/ Fail** |
|  |  |  |  |  |  |  |  |  |
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|  | **Total marks of all****Assesments** |  |
|  | **Total marks****of log book** |  | **Out of: 50** |
|  | **%age** |  |

Deputy / Controller of examination Director Medical Education

Sign Sign